



Protecting, Maintaining and Improving the Health of Minnesotans

REGISTRATION FORM
MOBILE HEALTH EVALUATION AND SCREENING PROVIDER

In accordance with Minnesota Statutes, 13.41, ALL DATA SUBMITTED ON THIS REGISTRATION FORM SHALL BE CLASSIFIED PUBLIC INFORMATION UPON ISSUANCE OF A REGISTRATION CERTIFICATE.

Please answer all questions completely and accurately to avoid unnecessary delay. A mobile health evaluation and screening provider shall register with the commissioner of Health and file the anticipated locations of practice, schedules, and routes annually no later than JANUARY 15.

MINNESOTA DEPARTMENT OF HEALTH
Division of Compliance Monitoring, Licensing and Certification Program
P.O. Box 64900
St. Paul, Minnesota 55164-0900

The undersigned hereby registers to be a Mobile Health Evaluation and Screening Provider subject to the provisions of Minnesota Statutes, Section 144.077.

A. Identification

- 1. Business Name
Business Street Address
Business City/State/Zip
2. Telephone Number: Area Code Number
After Hours Number: Area Code Number
Fax Number: Area Code Number
3. Name of county in which business is located

B. Ownership Ownership Code

- 1. Fill in the code which corresponds to the type of entity legally responsible for operating the facility.

GOVERNMENTAL NONFEDERAL

- 11. State
12. County
13. City
14. City-County
15. Hospital District or Authority

NONGOVERNMENTAL NONPROFIT

- 20. Church Related
21. Nonprofit Corporation
22. Other Nonprofit Ownership
OTHER
27. Tribal

NONGOVERNMENTAL FOR PROFIT

- 23. Individual
24. Partnership
25. Corporation
26. Group
28. Limited Liability Company
29. Business Trust
30. Housing & Redevelopment Authority

2. Give the name of the corporation, association, governmental unit, person, or partners legally responsible for the operation of this service. _____

Name and Mailing Address of Owners of Business _____

Federal ID # _____ State Tax ID # _____

3. If a corporation, give the date and place of incorporation. _____
Attach a Certificate of Authority to do business in Minnesota if incorporated in another state.

1. President _____

2. Agent(s) _____
(Individual(s) authorized to transact business with the Department of Health and upon whom all notices and orders shall be served. Include address if different than service address. Please attach another sheet of paper if necessary).

Address _____ City _____ State _____ Zip _____

C. Supervising Minnesota Licensed Physician

Name _____

Street Address _____

City, State, Zip _____

Telephone Number: Area Code _____ Number _____

D. Attach a list of the anticipated locations of practice, schedules, and routes.

E. Annual Registration

To the best of my knowledge, I certify that the information provided on this form is accurate and complete.

Signature of Authorized Agent: _____

Name (please print or type): _____

Title: _____

Date: _____

NOTE: If you have questions concerning this registration form, please call (651) 201-4115.